Supreme Court, U.S.
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No.

In the Supreme Court of the United States

October Term, 1993

Arthur Bradley Samura,
Petitioner,

v.

Kaiser Foundation Health Plan, Inc.,
The Permanente Medical Group, Inc., and
Kaiser Foundation Hospitals, Inc.

PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION ONE

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QUESTION PRESENTED

1. Does the federal Health Maintenance Organization Act allow federally qualified HMOs to charge their members fees for individual services in addition to monthly dues, if members are injured by third parties who financially compensate the member? 42 U.S.C. § 300e(b)(1)

PARTIES TO THE PROCEEDINGS

Petitioner Arthur Bradley Samura was plaintiff in the trial court, respondent at the California Court of Appeal, and petitioner to the California Supreme Court.

Respondents below are Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals, Inc. Each of them is part of a group informally known as "Kaiser-Permanente" that includes the following entities:

Kaiser Foundation Health Plan of the Northwest;
Kaiser Foundation Health Plan of Ohio;
Kaiser Foundation Health Plan of Colorado;
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.;
Kaiser Foundation Health Plan of Texas;
Kaiser Foundation Health Plan of Conn., Inc.;
Kaiser Foundation Health Plan of New York;
Kaiser Foundation Health Plan of North Carolina;
Kaiser Foundation Health Plan of Georgia, Inc.;
Kaiser Foundation Health Plan of Kansas City, Inc.; and, Kaiser Foundation Health Plan of Massachusetts, Inc.

(cont.)

Southern California Permanente Medical Group;
Northwest Permanente, P.C.;
Hawaii Permanente Medical Group, Inc.;
Ohio Permanente Medical Group, Inc.;
Colorado Permanente Medical Group, P.C.;
Permanente Medical Association of Texas;
Capital Area Permanente Medical Group, P.C.;
Northeast Permanente Medical Group, P.C.;
The Southeast Permanente Medical Group of Georgia, Inc.;
The Southeast Permanente Medical Group of North Carolina, P.A.; and,
Permanente Medical Group of Mid-America, P.A..

Kaiser Foundation Rehabilitation Center; and,
Kaiser Foundation Research Institute.

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PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION ONE

Arthur Bradley Samura respectfully petitions for a writ of certiorari to review the judgment and opinion of California Court of Appeal, First Appellate District, Division One.

OPINIONS BELOW

The opinion of the California Court of Appeal involving the construction and application of the federal Health Maintenance Act, 42 U.S.C. § 300e(b)(1) is reported at 17 Cal. App. 4th 1284 (App. 1-23). The statement of decision of the Superior Court of the State of California for the County of Alameda (Girard, J.) is unreported (App. 24-32). A related opinion of the United States District Court for the Northern District of California (Schwarzer, J.), remanding this case after removal, is reported at 715 F. Supp. 971 (N.D. Cal. 1989) (App. 33-38).

JURISDICTION

The judgment of the California Court of Appeal, First Appellate District, construing 42 U.S.C. § 300e(b)(1), was entered on August 17, 1993. Thereafter, on December 16, 1993, the California Supreme Court denied a timely filed Petition for Review (App. 39). It raised the question of the construction and application of 42 U.S.C. § 300e(b)(1). The jurisdiction of this court is invoked under 28 U.S.C. § 1257(a).

STATUTORY PROVISION INVOLVED

42 U.S.C. § 300e(b)(1) is set out in the appendix (App. 40-42).

STATEMENT OF THE CASE

Petitioner Arthur Samura had been a member of Kaiser-Permanente, a federally qualified Health Maintenance Organization (HMO), for ten years before he was injured in a non-work related auto accident. He received medical care from Kaiser for his injuries. He sued the other driver. Then Kaiser sent him a demand letter enclosing a copy of the third party liability (TPL) term from its member contract.[1] The TPL term provides that Kaiser members must pay "Non-Member Rates" for each service they are furnished if they are injured by a third party who financially compensates them. These charges are in addition to monthly member dues that were prepaid by or on behalf of members. The TPL term provides that Kaiser may collect a member's entire recovery, up to one-hundred percent of the sum paid by the third party, if the charges calculated according to Non-Member Rates equal or exceed the recovery.

Petitioner was surprised. He had read Kaiser's booklet, but he did not notice, or did not understand, the meaning of the TPL term. Petitioner believed that he was entitled to all of the basic health care he needed, without paying Non-Member Rates too, because he prepaid dues.

Petitioner filed a complaint against Kaiser in the Superior Court for the State of California for the County of Alameda. It alleged, on behalf of petitioner and the general public, that Kaiser's TPL term and associated practices violate California's Unfair Trade Business Practices Act, California Business and Professions Code

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1 Kaiser's one-thousand word-long TPL term is set out *in haec verba* in the Appendix (App. 43-46).

§ 17200, California's 'little FTC Act.' This law prohibits any unlawful, unfair or deceptive business practice. Recently, the California Supreme Court quoted with approval the California Attorney General's explanation of how unlawfulness is determined under the Unfair Trade Practices Act: "'[I]n essence, an action based on Business and Professions Code section 17200 to redress an "unlawful" business practices 'borrows' violations of other laws and treats these violations, when committed pursuant to business activity, as unlawful practices independently actionable under section 17200 et seq. and subject to the distinct remedies provided thereunder.'" *Farmers Ins. Exchange v. Superior Court*, 2 Cal. 4th 377, 383 (1992) (emphasis added).

HOW THE FEDERAL QUESTION WAS PRESENTED

On April 10, 1989, petitioner filed his First Amended Complaint alleging that Kaiser is subject to the federal HMO Act, and that Kaiser's TPL term violates the provisions and policy of the Act, in particular, 42 U.S.C. § 300e(b)(1) and, therefore, the TPL term is "unlawful" *per se* within the meaning of California's little FTC Act.

Trial to the court took place in one week in March, 1991. Petitioner cited to the HMO Act structure to show that TPL terms are unlawful. The HMO Act is composed of a general rule that HMOs must provide all health care in exchange for prepaid dues (fixed without regard to the frequency, extent, or type of services provided) followed by certain enumerated exceptions to this general rule. 42 U.S.C. § 300e(b)(1). TPL terms do not fit within the enumerated exceptions to

the general rule.

Petitioner also cited to the legislative history of 42 U.S.C. § 300e(b)(1) showing that Congress intended that HMOs operate on a prepaid basis to the greatest extent possible. Finally, petitioner cited to the history of the implementation of the HMO Act. Regulations permitting TPL terms were proposed, but ultimately not adopted, by the Department of Health, Education and Welfare, the agency that was delegated the power to implement the federal HMO Act (later succeeded by the Department of Health and Human Services).

On October 10, 1991, the trial court entered judgment. The court rejected petitioner's claim that Kaiser's TPL term and practices violate 42 U.S.C. § 300e(b)(1) (App. 28). The trial court concluded that 42 U.S.C. § 300e(b)(1) and its regulations do not expressly authorize, or prohibit, TPL terms, and, because Kaiser's TPL had not been disapproved by the Department of Health and Human Services, the TPL term was not unlawful (App. 22-23).

However, the court entered judgment for petitioner on other grounds, ordering Kaiser to rewrite its TPL term in plain English and include equitable limits on Kaiser's claim to 100% of an injured member's recovery (App. 24-32).[2] Kaiser appealed, and the court of appeal reversed the judgment in favor of petitioner (App. 1-23).

Petitioner cross-appealed from the trial court's ruling that the TPL term and practices do not violate the federal HMO Act. On August 17, 1993, the Califor-

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2 Petitioner's case against the third party had liability problems. He settled for only $2,500 for a badly broken arm, six weeks lost income, amounting to approximately $3,000, and hundreds of dollars in property damage. At trial, Kaiser waived its entire TPL claim against petitioner.

nia court of appeal denied petitioner's cross-appeal. The court of appeal ignored that Congress, through its enumerated exceptions, limited the HMOs' power to surcharge their members. The decision simply concludes that TPL terms are permissible because they are not expressly prohibited by 42 U.S.C. § 300e(b)(1). The court of appeal did not discuss rules of statutory construction, or the legislative history of the HMO Act and the evolution of the Act's regulations on which petitioner relied to show that the HMO Act prohibits TPL terms (App. 23).

Petitioner filed a timely Petition for Review to the California Supreme Court requesting review of whether Kaiser's TPL term violates the federal HMO Act. It was denied, without opinion, on December 16, 1993 (App. 39).

The issue of the meaning of the federal HMO Act was raised properly at each stage of the proceedings, and is appropriate for the exercise of the Court's discretionary certiorari jurisdiction because, "[d]espite the absence of a conflict, state court decisions involving the construction and application of federal statutes or treaties may be reviewed on certiorari where the questions is sufficiently important." R.L. STERN, E. GRESSMAN & S.M. SHAPIRO, SUPREME COURT PRACTICE at 238 (6th Ed. 1986). There is no independent state ground for the decision because California's little FTC Act "borrows" 42 U.S.C. § 300e(b)(1) exactly as it is, without change, to supply a standard for enjoining Kaiser's TPL practice as "unlawful."

REASONS FOR GRANTING THE PETITION

The main question here — whether the federal HMO Act prohibits HMOs from charging fees-for-services to injured members — is worthy of certiorari because it concerns an area of vital interest, health care, and it is important to over five hundred federally qualified HMOs nationwide, important to over thirty-three million persons who are members of federally qualified HMOs, and tremendously important to hundreds of thousands of injured members who face active TPL claims by their HMOs. The question also is important to the efficient administration of justice because TPL claims make the associated tort litigation more difficult to settle, consuming scarce judicial resources, especially as the amount of the TPL claim increases in proportion to the amount recoverable or recovered from the third party. Allocating of settlements equitably between HMOs and their members is difficult if not impossible, and a subsequent round of litigation often follows when the parties cannot agree on the proper allocation of recoveries.[3]

In Kaiser's own words, the question of whether TPL terms are enforceable is of "across-the-board con-

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3 There are substantial problems in apportioning recoveries between HMOs and their members because HMOs provide services, not indemnification. Kaiser's trial testimony revealed that it does not know how much it costs to provide services, and Kaiser adopts the fees of others to charge its members in TPL claims. Cases by insurers seeking reimbursement of sums paid are fraught with problems and burden courts. *See, e.g., Powell v. Blue Cross & Blue Shield*, 581 So.2d 772 (Ala. 1990); *Westendorf by Westendorf v. Stasson*, 330 N.W.2d 699 (Minn. 1983).

cern to California's health care community."[4] Numerous *amici curiae* echoed Kaiser's proclamation of the importance of the question in connection with petitioner's request for review by the California Supreme Court.[5] The California Court of Appeal's approval of Kaiser's TPL term mutates the HMO-member relationship in which consumers buy health care on a fixed prepaid basis and shift the financial risk to their HMOs into something quite different. Contrary to the law, the Opinion allows HMOs to charge their members Non-Member Rates based on the frequency, extent or kind of health service actually furnished to a particular member. Finally, because neither the HMO Act nor its regulations authorize TPL terms, there are no reasonable controls on the surcharges federally qualified HMOs impose on their injured members. *See Zinman v. Shalala*, 835 F. Supp. 1163 (N.D. Cal. 1993).

Certiorari should be granted, the HMO Act properly interpreted, and the decision below reversed.

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4 Kaiser's Answer to Plaintiff-Respondent's Petition for Rehearing in the California Court of Appeal, at p. 1. Kaiser offers HMO memberships in sixteen states, and the interpretation of the HMO Act is equally important in the other states.

5 Letter briefs were submitted emphasizing the importance of TPL claims to HMOs and insurers by the following entities: Blue Shield of California; The Prudential Insurance Company of America; FHP [Family Health Plan] Health Care; Southern California Permanente Medical Group; California Chamber of Commerce, Association for California Tort Reform; California Manufacturers Association, and, joining in one letter brief were Blue Cross of California, California Care, Guardian Life Insurance Co. of America, Health Net, Inc., Humana Health Plans, I.T.T. Hartford Life Insurance Co., John Hancock Insurance Company, Massachusetts Mutual Life Insurance Co., Nationwide Life Insurance Co., Pacific Mutual Life Insurance Co., Phoenix Home Life Mutual Insurance Co., Principal Mutual Life Insurance Co., Washington Nation Insurance Co.

A. Many Persons Are Directly Affected By The Issue Presented.

"Kaiser-Permanente" is the informal name for a group of related organizations that comprise the largest nongovernmental health care delivery system in the world. In 1992, Kaiser's nationwide enrollment was 6.6 million members. The TPL term is a non-negotiable part of *every* Kaiser contract.

In 1991, at the time of trial, Kaiser's Northern California region in which petitioner is enrolled had 2.4 million members and Kaiser in that region alone was asserting 25,000 active TPL claims. Kaiser also is prosecuting scores of suits against its members (and their attorneys in the members' actions against the third party wrongdoers) in state and federal courts in northern California. Assuming that TPL enforcement is about equal throughout the Kaiser system, then Kaiser is asserting well over a half-a-million active TPL claims against members in sixteen states and in the District of Columbia.

"The Federal HMO Act of 1973 . . . helped HMOs grow from merely an idea in California, into a nationwide industry serving over 33 million enrollees. The Act established the federal qualification process that has become a seal of approval for over 500 plans." Figa & Tag, *Redefining Full and Fair Disclosure of HMO Benefits and Limitations*, 14 SETON HALL LEG. J. 151, 152 (1990). The proper interpretation of the rights and duties of HMOs and their members under the federal HMO Act is of substantial importance to the many persons affected.

B. TPL Claims Do Not Make Dollars Or Sense.

1. The financial contribution from TPL claims to HMOs is minuscule.

The common theme of Kaiser and its *amici* in the California Supreme Court was that TPL claims are a significant aspect of cost containment because such claims generate revenue from third party wrongdoers, and that revenue in turn reduces the price of HMO memberships to the public. The monthly cost of Kaiser membership, at the time of trial in 1991, for an individual was $119.50; for a two-person family, $237.00; and, for a family of three or more, $314.55.

In fact, revenue from TPL claims does not significantly reduce the cost of memberships to the public. Kaiser collected pursuant to its TPL term the equivalent of fifteen cents to twenty-five cents per member per month from 1988 to 1990. Blue Shield of California, one of Kaiser's *amici* below, collected slightly less than twenty cents per member per month. Moreover, these twenty-five cents and twenty cents per member per month contributions are gross amounts, not adjusted to reflect the cost of implementing the TPL practice, further reducing the *de minimis* contribution of revenue from TPL claims. These amounts do not include the additional costs to the public if settlements of underlying personal injury cases are impeded by TPL claims, or if subsequent litigation between HMOs and injured members arises because of disputes about apportionment of settlements.

Eliminating Kaiser's TPL term would not affect sales of memberships. A group-accounts marketing

supervisor of Kaiser confirmed what is obvious, testifying at trial that an increase of twenty-five cents per member per month in the rates would not "make or break" any sale. Recently, a proposal to charge registration fees to federal HMOs drew objections from the HMO industry because the fees would increase the HMO's administrative cost by one-percent, and thereby make HMO membership more expensive. The regulators stated that a possible one-percent increase in member dues that might result was "negligible." 52 Fed. Reg. 22311, 22318 (1987). TPL revenue to Kaiser of twenty-five cents per member per month is less than one-quarter of one-percent of its operating budget, and represents less than one-quarter of one-percent of an individual's monthly dues.

Moreover, the real source of soaring health care costs appears to be unnecessary care.[6] Health care cost containment measures are increasingly directed towards creating incentives for providers to furnish only necessary care and away from fees-for-services charges. Couch, *Employers' Role in Improving Medical Care Value*, 14 SETON HALL LEG. J. 65, 70-71 (1990). TPL terms neither help reduce unnecessary care nor significantly reduce the cost of health care to the public.

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6 Studies indicate that as much as 25% of hospital care is unnecessary. Hirshfeld, *Should Third Party Payors of Health Care Services Disclose Cost Control Mechanism to Potential Beneficiaries*, 14 SETON HALL LEG. J. 115, n.3 (1990).

2. TPL claims against injured members contravene the HMO Act because they render dues payments illusory and cause members great harm.

In the best of circumstances, injured members are able to collect full compensation for their losses from third party wrongdoers. Each of Kaiser's arguments in support of its TPL claim practice assumes that a full recovery is common, when in fact full recovery is most unusual. In the usual case, because of various factors such as underinsurance, compromise or comparative fault, tort victims do not receive full compensation for their losses. Undercompensation makes fair apportionment between the HMO and its injured members difficult, if not impossible. *See*, the basis of the Department of Health, Education and Welfare's refusal to allow TPL terms: "in tort settlements, it is often not possible to determine the portion of settlements allocable to medical costs." 39 Fed. Reg. 37309 (1974). Further, tort victims almost always pay their attorneys a percentage of the whole, frequently one-third or more, so even a "fully" compensated tort victim is not made whole. *See, Annotation*, 77 A.L.R. 3d 415, 421 (1977).

HMO members expect their HMO to take care of their health care needs in exchange for prepaid dues, and they do not expect to have to pay surcharges from their tort recoveries. As the California court of appeal concluded, the TPL term "represents a departure from the general pattern of the health service agreement that may arguably result in surprise." (App. 15). The problems inherent in HMO TPL claims simply show the wisdom of the Congressional decision to prohibit such terms. Further, the economics of TPL terms do

not justify fashioning a judicial exception to the HMO model Congress has selected. The Court should grant review and ensure that federally qualified HMOs satisfy the expectations of Congress and the public.

C. This Court Should Interpret The HMO Act So The Public Receives Benefits Which It Reasonably Expects And To Which It Is Entitled.

The prohibition against TPL terms in HMO agreements is inherent in the structure and content of the HMO Act. The Act states the general rule that health care shall be provided in exchange for prepaid member dues fixed without regard to the frequency, extent, and kind of services actually furnished. Then the statute states specific exceptions to the general rule. 42 U.S.C. § 300e(b)(1). Where a statute states a general rule and specific exceptions, no other exceptions are allowed. *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-617 (1980); *Boudette v. Barnette*, 923 F.2d 754, 756-757 (9th Cir. 1991).

The prohibition against TPL terms is expressed in the HMO Act's regulations as well. "An HMO may not offer to provide or arrange for the provision of basic health services on a prepayment basis which . . . are limited as to time and cost *except in a manner prescribed by this subpart.*" 42 C.F.R. § 417.102(e) (emphasis added); *see id.* at § 417.104(a). The regulations do not allow TPL terms calling for payments based on the time and cost of treatment.

The failure of the courts below to correctly interpret and apply the federal HMO Act calls for certiorari.

D. The Legislative History Of The HMO Act Fully Supports The HMO Act's Prohibition Against TPL Terms.

In 1973, Congress passed the HMO Act to increase consumer options by encouraging development of a health care delivery system operating on a prepaid basis in competition with traditional fees-for-services insurance. S. REP. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. CODE CONG. & ADMIN. NEWS 3033, 3039. The original Senate bill did not allow HMOs to charge members more than prepaid dues; HMOs could not even charge nominal co-payments for selected services. S. REP. No. 93-621, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. CODE CONG. & ADMIN. NEWS 3126.[7]

The law as enacted in 1973 allowed HMOs to charge nominal co-payments, but those surcharges were to be the "absolute upper limits" on additional charges to members. S. REP. No. 93-621, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. CODE CONG. & ADMIN. NEWS 3126. And, in keeping with the basic premise that HMOs must provide all basic health care in exchange for periodic payments fixed in amount "without regard to the frequency, extent or kind of health service actually furnished" 42 U.S.C. § 300e(b)(1)(B), HMOs must reimburse members for expenses of necessary emergency care provided by non-plan providers. S. REP. No. 93-621, 93rd Cong., 1st Sess., *reprinted*

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7 *See e.g.*, Rosoff, *The Federal HMO Assistance Act*, 13 AM. BUS. L.J. 137, 155 (1975): "Greatly aggravating the marketing difficulties inherent in providing a comprehensive benefit package is the HMO Act's limitation on copayments. . . . The Senate bill, true to its purist philosophy, permitted no copayments whatsoever."

in 1973 U.S. CODE CONG. & ADMIN. NEWS 3129.

The Department of Health, Education and Welfare was charged with implementing the HMO Act. HEW proposed regulations that expanded the revenue sources for HMOs. The proposed regulations allowed that an HMO (1) could impose co-payments at the time services were provided, 42 C.F.R. §§ 110.103(d), 110.104(b); (2) could exclude coverage for inpatient benefits where other insurance was available, *id.* at § 110.108(b)(11); (3) could exclude coverage where workers' compensation would cover the services, *id.*; and, (4) must pursue TPL claims where third parties were legally liable for the supplemental services rendered to the member, *id.* at § 110.104(c). 39 Fed. Reg. 16421, 16424-16426 (1974).

However, after the comment period, HEW withdrew the regulation allowing HMOs to exclude coverage for members who had other insurance, or who were entitled to worker's compensation benefits. 39 Fed. Reg. 37308, 37209 (1974). Instead, the regulation finally adopted stated the general rule that HMOs must provide all basic health care, but allowed HMOs to seek reimbursement from worker's compensation payors where not barred by state law. 42 C.F.R. §§ 110.105(b); 110.106(c), *see* 39 Fed. Reg. 37209, 37314 (1974). The proposed regulation allowing TPL terms was entirely deleted, in part, because of the inability of HMOs to identify other payment sources in every case, and in part because "in tort settlements, it is often not possible to determine the portion of settlements allocable to medical costs." *Id.* at 37309.

In 1978, exceptions were added to the HMO Act's general rule that federal HMOs must provide services for prepaid dues (fixed without regard to the frequency and kind of services needed) and nominal copayments.

HEALTH MAINTENANCE ORGANIZATION ACT of 1978, Pub. L. No. 95-559, § 300e, 92 Stat. 2139 (1978). The amendments permitted HMOs to seek reimbursement from worker's compensation payors and other insurers, and limited the HMOs' duty to provide services during wartime or disasters. *Id.* No exception was added allowing HMOs to seek reimbursement from their member's tort recoveries.[8] And, because the TPL term does not fit within the specific exceptions to the HMO Act's general rule, TPL terms are prohibited. *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-617 (1980).

In 1981, The HMO Act was amended to change the community rating system. This change allowed HMOs to set different premium rates for different groups. THE OMNIBUS BUDGET RECONCILIATION ACT of 1981, Pub. L. 97-35, 95 Stat. 575 (1981). Congress did not authorize HMOs to impose TPL terms, even though such terms might affect the rates charged by HMOs. Congress did not increase the limited, specific exceptions to its mandate that HMOs provide all basic health care on a prospective basis. 42 U.S.C. § 300e(b)(1). At the very same time, Congress amended the Medicaid

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8 In stark contrast, the HMO Act was amended to clearly express the HMO member's right of reimbursement *from the HMO. Id.*

The legislative history of the 1978 amendments shows that Congress authorized "narrow limitations" that "could only apply" to the circumstances described in the amendment. S. REP. No. 95-837, 97th Cong., 1st Sess., 2, 19, *reprinted in* 1978 U.S. CODE CONG. & ADMIN. NEWS 4935, 4936, 4966. Congress also limited the Secretary's discretion to authorize exceptions in addition to those set forth in the HMO Act. *Id.* at 9-10, 1978 U.S. CODE CONG. & ADMIN. NEWS at 4943-4944.

The Congressional debate also reflects that Congress intended only very limited, well-defined, express exceptions to the general rule that HMOs operate on revenue from fixed prepaid dues. *E.g.* 125 CONG. REC. 22127, 32216, 37063 (1978).

Act to limit the state's duty to "collect third party liabilities" in certain instances. THE OMNIBUS BUDGET RECONCILIATION ACT of 1981, Pub. L. 97-35, 95 Stat. 816. These concurrent amendments show that Congress will be precise about TPL terms. The absence of an exception for "third party liabilities" in 42 U.S.C. § 300e(b)(1) shows that federally qualified HMOs may not impose charges on a fees-for-services on injured members through TPL terms.[9]

E. The Decision Cannot Be Sustained On Independent State Grounds.

The California court of appeal decided that TPL terms do not violate the federal HMO Act, and that, as a result, Kaiser's TPL term does not violate California's little FTC Act (App. 22-23). There are no independent state grounds for the decision, even though it refers to state law, because the state and federal grounds involved in the decision are inextricably interwoven. *Enterprise Irrigation District v. Farmers Mutual Canal Co.*, 243 U.S. 157, 164 (1917).

Kaiser argued below (and is expected to reassert) a contention that further analysis of the meaning of the federal HMO Act is inappropriate because California's little FTC Act cannot rest on (or "borrow") the federal HMO Act to establish a standard of unlaw-

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9 Here again, the legislative history of the 1981 amendments fully supports a plain reading of the HMO Act. The amendments were passed to make HMOs more competitive. H.R. REP. NO. 97-158, 97th Cong., 2nd Sess., at 1, 13 (Vol. II), *reprinted in* 1981 U.S. CODE CONG. & ADMIN. NEWS 1180. However, Congress did not try to make HMOs more competitive by adding to the limited, exceptions to its rule that HMOs provide all basic health care on a prospective basis. *Id.* at 6-7, 1981 U.S. CODE CONG. & ADMIN. NEWS at 1174.

fulness. Kaiser's contention is not based on state law grounds but instead blurs together federal questions of preemption and supremacy. Essentially, Kaiser erroneously contends that the remedies of the little FTC Act are preempted or unavailable wherever the "borrowed" federal law does not provide a private right of action.[10]

1. California's little FTC Act reaches *any* unlawful conduct, including violations of federal law.

California's little FTC Act prohibits ""anything that can properly be called a business practice and that at the same time is forbidden by law."'[Citation.]" *Farmers Ins. Exchange v. Superior Court, supra*, 2 Cal. 4th at 395; *accord, Bank of the West v. Superior Court*, 2 Cal. 4th 1254, 1264, 1266-1267 (1992). California courts are expressly authorized to enjoin violations of state or federal law that are harmful to consumers. California law provides that "violation of any law of this state or *any federal law* . . ." may be enjoined. Cal. Bus. & Prof. Code § 321 (emphasis added). Thus, there is no state law ground that prevents California's FTC Act from reaching Kaiser's violations of the federal HMO Act.

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10 Kaiser's contention that California's little FTC Act cannot "borrow" the federal HMO Act to supply a standard for determining whether Kaiser's TPL term is "unlawful" does not concern an independent state ground for the decision. However, Kaiser's contention is addressed at this point because it cloaks its argument in state law garb, creating the appearance of issues of state law rather than issues of federal preemption.

The broad scope of California's little FTC Act simply mirrors the federalism that forms our country. "We start with the premise that nothing in the concept of our federal system prevents state courts from enforcing rights created by federal law." *Dowd Box Co. v. Courtney*, 368 U.S. 502, 507-508 (1962). When Congress enacts a law, it establishes a policy for each of the states. "That policy is as much a policy of [the State] as if the act had emanated from [the State's] own legislature, and should be respected accordingly in the courts of the State." *Second Employer's Liability Cases*, 223 U.S. 1, 57 (1911).

Accordingly, California courts adopt, refer to, and enforce the policies articulated in federal law. In, *Solorzano v. Superior Court*, 10 Cal. App. 4th 1135 (1993), the court used California's little FTC Act to enjoin violations of Medicare law. 42 U.S.C. § 1395, *et seq*. In another case, the court used the requirements of the federal HMO Act to issue an injunction safeguarding the independence of an HMO. *Health Maintenance Network v. Blue Cross of So. Cal.*, 202 Cal. App. 3d 1043 (1988).[11] Federal law is used to establish the standard of due care that juries apply to decide some tort actions. Cal. Evid. Code § 669; *Fagerquist v. Western Sun Aviation, Inc.*, 191 Cal. App. 3d 709, 717-720 (1987). Federal law so animates some state law actions that juries may independently measure whether a business has complied with federal regulations — even where a

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11 Other states also use the standards articulated in federal laws to define proper business conduct. *See In re Scrimpsher*, 17 Bankr. 999, 1009 (1982) (action based on thefederal Fair Debt Collection Practices Act, 15 U.S.C. § 1692); *Dial Corp. v. Manghnani Inv. Corp.* 659 F. Supp. 1230 (D.Conn.1987) (action based on Lanham Trade Mark Act, 15 U.S.C. § 1141.)

federal agency with exclusive jurisdiction to enforce the federal law has certified compliance. *Elsworth v. Beech Aircraft*, 37 Cal. 3rd 540, 547-552 (1984).

2. The remedies provided by California's little FTC Act do not conflict with the enforcement scheme in the federal HMO Act, even though the federal HMO Act does not provide a private right of action.

Kaiser's preemption argument turns on the premise that Samura's action uses state law to create a private right of action in the federal HMO Act. However, the lack of a private right of action in the federal HMO Act is immaterial because petitioner does not seek relief under the HMO Act. As Judge Schwarzer explained rejecting Kaiser's removal petition when it asserted federal question jurisdiction based on the HMO Act claim: "The amended complaint did not change the nature of the underlying claim. The reference to the federal HMO Act merely provides an added standard governing application of the Unfair Practices Act." *Samura v. Kaiser Foundation Health Plan, Inc.*, 715 F. Supp. 971, 972 (N.D. Cal. 1989) (App. 38).

Actions under California's little FTC Act do not seek remedies provided in the underlying federal statute. Instead they invoke remedies provided in the state Act itself, principally injunctive relief needed to protect the public welfare. As a result, the lack of a private right of action in the "borrowed" law is irrelevant to the propriety of an injunction under California law. *Committee on Children's Television v. General Foods Corp.*, 35 Cal. 3rd 197, 210-211 (1983); *see also Farm-*

ers Ins. Exchange v. Superior Court, supra, 2 Cal. 4th at 395 ("Unfair Practices Act applies in many situations in which no administrative process is available to address the challenged practice.").

Kaiser's preemption argument is based entirely on the lack of a private right of action in the federal HMO Act. However, preemption is to be determined by the language and purpose of the underlying federal law. *Morales v. Trans World Airlines, Inc.*, ___ U.S. ___; 112 S.Ct. 2031; 119 L.Ed.2d 157 (1992). The most concise response to Kaiser's contention that preemption will be implied from the lack of a private right of action alone is found in *Solorzano v. Superior Court*, 10 Cal. App. 4th 1135 (1993). The defendant HMO in *Solorzano* "contend[ed] that the mere existence of a federal regulatory scheme makes state injunctive relief inappropriate under general principles of equity. The cases [cited by the HMO] are inapposite because, unlike the case at bench, both deal with fields absolutely and entirely preempted by federal law (immigration and Indian affairs.)" *Solorzano, supra*, at 1148, n. 14.[12]

Mischief would result if the lack of a private right of action, standing alone, resulted in the preemption of state laws enacted to protect public welfare. For instance, Congress did not provide a private right of action under the FTC Act. Nonetheless, most States, including California, adopt FTC regulations and rulings as the standard for violations under their own little

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[12] The defendant HMO in *Solorzano* and Kaiser both rely on the same two cases involving immigration and Indian affairs: *I.e., Naegele OutdoorAdvertising Co.*, 38 Cal. 3d 509 (1985) and *Diaz v. Kay-Dix Ranch*, 9 Cal. App.3d 588 (1970). These cases are also referred to elliptically in the court of appeal's opinion (App. 23).

FTC Acts. *See People ex rel Mosk v. National Research Co. of Cal.*, 201 Cal.App.3d 765 (1962); *Barquis v. Merchant's Collection Assn.*, 7 Cal. 4th 94, 109-111 (1972). These important state laws are not preempted simply because Congress did not provide a private right of action in the federal FTC Act.

3. The preemptive scope of the federal HMO Act is express and narrow.

The HMO Act expressly provides that only state laws that thwart the formation of HMOs are preempted. 42 U.S.C. § 300e-10. Indeed, every state law preempted by the HMO Act must be identified and enumerated. *Id.* Moreover, Congress expressly encourages the states to adopt the standards of the HMO Act. The "Federal HMO Act sets a policy that HMOs are to be encouraged and held to certain standards." S. Rep. No. 100-204, 100th Cong., 2ndSess. (p. 11), *reprinted in* 1988 U.S. CODE CONG. & ADMIN. NEWS 3239. State laws consistent with the standards of the federal HMO Act are not to be preempted. (*Id.*)

The purposes of the HMO Act are advanced by state laws that adopt and ensure compliance with the standards of the Act. As the court of appeal poignantly concluded in rejecting the analogous argument that Medicare preempts actions based on California's little FTC Act: "Congress clearly recognized the need for state and local assistance in regulating the marketing of HMOs . . . and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the help it can get." *Solorzano v. Superior Court, supra*, 10 Cal. App. 4th at 1149.

California's Little FTC Act merely protects Californians from HMOs that fail to meet the standards articulated by Congress; it does not hinder HMO formation or federal enforcement efforts, and it is not preempted.

CONCLUSION

A key concern of Congress when it passed the federal HMO Action 1973 was to foster an alternative health care delivery system to the traditional 'fees-for-services' method. To satisfy this concern, the HMO Act provides that HMOs shall accept the financial risk of health care of their members on a prospective basis in exchange for prepaid, periodic payments only. 42 U.S.C.§ 300e(b)(1)(A). HMOs must determine the amount of periodic payments without regard to the health care services actually furnished to any individual member. 42 U.S.C. § 300e(b)(1)(B). In addition, HMOs may charge nominal copayments at the time services are rendered. *Id.*

In 1978, Congress approved specific exceptions to the general rule of 42 U.S.C. § 300e(b)(1); the exceptions allow HMOs to coordinate insurance benefits and, if state law permits, HMOs may charge the workers' compensation insurance carrier or employer. There is no authorized exception allowing HMOs to pursue "third party liabilities."[13] Further, the limited discretion granted the Secretary of HHS (then HEW) does not include the power to expand on the exceptions enumerated in the HMO Act.

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13 Compare HMO Act with Medicaid. 42 U.S.C. §300e(b)(1); 42 U.S.C. §1396a(a)(25).

TPL terms substantially undermine the purpose of the HMO Act. Such terms do not make health care significantly more affordable to the public, but may — and often do — inflict harsh or unconscionable results on individual injured members. The California Court of Appeal erred when it authorized an exception for TPL terms that should not have been read into the HMO Act. The Opinion ignored the HMO Act's structure, and set a precedent that essentially allows HMOs across the country to impose any conditions on their members not expressly prohibited by law.

This petition for a writ of certiorari should be granted.

Respectfully submitted.

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